HARVARD UNIVERSITY HEALTH SERVICES

Medical Care- Cost Sharing Assistance

This **temporary** Medical Care-Cost Sharing Assistance funding has been designated by Harvard University Health Services to assist students with unexpected costs that may be creating a financial barrier to receive medical care. Considering these extraordinary circumstances, this fund can help address costs for medical care that may not be addressed with the recent benefit changes to the Student Health Insurance Plan from **August 1st, 2020- July 31st, 2021.**

When applying for these Funds, the following points should be kept in mind:

1. The funds will be granted only for out of pocket costs totaling at least $500.00 for **care covered by the Student BC/BS plan.**
   a. *Pharmacy costs are ineligible* for this fund and cannot be included in your total out of pocket costs
   b. The funds cannot not be used for students who have waived the Student BC/BS Plan.

2. The funds may be used to cover specialist/diagnostic visit copayments, outpatient mental health visit copayments, and deductible and co-insurance for **covered medical services**.

3. The **minimum amount you must have paid out of pocket is $500.00** and the **maximum amount awarded will be $1,200** to be paid for assistance per student for care administered between **August 1st 2020-July 31st, 2021.**

4. Grants will be paid only from a **receipted facility/clinic billing statement.**

5. All applications will be reviewed and approved by the Director of the University Health Services.

6. Your application should explain why you are applying for aid, care/visit information, and include all relevant invoices and receipts.

7. If you are awarded some funding, the **amount only** will be shared with your school's Financial Aid Office.

8. **Return completed form to: Patadvoc@huhs.harvard.edu To send via secure file share, please email directly to request this.**

   If you need more information or assistance in filling out this form, please contact the Patient Advocate at 617-495-7583 or via email: patadvoc@uhs.harvard.edu

Rev. 11/18/2020

UNIVERSITY HEALTH SERVICES
Medical Care-Cost Sharing Assistance

Date:______________________________ Check One:

Name: ______________________________ ☐ Harvard Undergraduate
Class ______________________________

Current Mailing Address: ☐ Radcliffe Undergraduate
Class _______________

___________________________________ ☐ Graduate School
___________________________________ Class _______________

Phone:______________________________ Name of School__________________________

Email:______________________________ University I.D. No ______________________

☐ Is U.S. Citizen

☐ Non-resident Alien

☐ Resident alien

☐ Is on a Harvard Payroll

☐ Is not on a Harvard Payroll

1. Are you a member of the Harvard Graduate Student Union? ☐ Yes ☐ No
2. Have you already explored or secured finding assistance through this union resource? ☐ Yes ☐ No

To be eligible for this funding assistance program:

- Must be enrolled in both components of the Harvard University Student Health Program (Student Health fee + Student Health Insurance Plan)
- The required minimum amount of out of pocket medical costs to apply for this assistance is$500.00 (Pharmacy costs are ineligible for this fund)
- The maximum amount awarded per student will be $1,200.00
- **Medical Care must have occurred between August 1st, 2020-July 31st, 2021.**

Please list the following medical costs that you have incurred:

Date of Visit	Type of Specialty/Department	Cost of Visit Billed to you

Please includes detailed invoices and receipts of payment if available

To be completed by Student

☐ I understand that this award is based on financial need and I confirm that these costs present a financial hardship for me.

I authorize Harvard University Health Services to discuss only the award amount (if applicable) with the Financial Aid Office of Harvard University.

_______________________________ _____________________

Signature, Student Date

Name of Financial Aid Officer: _______________________________

Phone No.____________________________ Email Address ___________________________

Return completed form to: patadvoc@huhs.harvard.edu To send via secure file share, please email directly to request this.

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Award Confirmation (if applicable)

To be completed by HUHS and returned to FAO

Total amount awarded______________________________Date_______________

Patient Advocate signature___________________________________Date: ________________

Disbursement of award is via:

☐ Check